

Charles Street Obstetrics~Gynecology Associates, P.A.

Robert E. Ottenritter, M.D., F.A.C.O.G.

Onkar N. Singh, M.D., F.A.C.O.G.

Laura M. Erdman, M.D., F.A.C.O.G.

PATIENT INFORMATION

NAME _____ DOB _____

ADDRESS _____ HOME PHONE _____

CITY/STATE _____ WORK PHONE _____

ZIP _____ EMPLOYER _____ CELL PHONE _____

PRIMARY CARE PROVIDER (PCP): _____ PHONE: _____

MARITAL STATUS: S M W D SEP SS# _____

E-MAIL _____ PREFERRED PHARMACY _____

SPOUSE OR NEAREST RELATIVE:

NAME _____ RELATIONSHIP _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE _____ SS# OF POLICY HOLDER _____

POLICY HOLDER _____

RELATIONSHIP _____ DOB _____

MEMBER ID # _____ GROUP # _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

SECONDARY INSURANCE:

INSURANCE _____ SS# OF POLICY HOLDER _____

POLICY HOLDER _____

RELATIONSHIP _____ DOB _____

MEMBER ID # _____ GROUP # _____

SIGNATURE _____ DATE _____

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The following are current policies in effect for patients of Charles Street Ob/Gyn Associates. After you have reviewed these policies, please sign and date this form. You will be given a copy for your own files.

1. You must present a current active insurance card at the time of your visit. If you do not have your insurance card, it may be necessary to reschedule your appointment.
2. All co-pays, deductibles and co-insurance payments are due at the time of your visit.
3. It is against federal law and considered billing fraud for physicians to not bill patients for the balance due after an insurance company payment.
4. There is a yearly \$25.00 administrative/convenience fee per patient to offset the increased cost of paperwork required by insurance companies, paperwork required by employers, and paperwork required by regulators. This fee is not covered by your insurance company.
5. Please allow 2 weeks for the completion of obstetric and surgical disability forms.
6. All accounts 90 days past due will be charged 1.5% interest per month.
7. All outstanding balances must be paid in full or a payment plan set up in order to be seen.
8. If your insurance lapses or you do not have active coverage, you are responsible for all charges incurred while you are without insurance.
9. Self-pay patients must pay at the time of service. If there are extenuating circumstances, please speak with the Office Manager about payment arrangements.
10. To cancel an appointment, you must give at least 24 hrs notice, or a \$50.00 cancellation fee will be charged.
11. If you miss three or more appointments without providing advance notice, you will receive a certified letter releasing you from the practice.
12. If you are late for your appointment, you may be asked to reschedule for another day.
13. There is a fee per page for copies or transfer of patient records.
14. PRESCRIPTION REFILLS – No refill request will be accepted after 12:00 noon on Fridays, during weekends or holidays. Please plan ahead. No refills will be given to patients who have not been seen within the last year. PLEASE HAVE YOUR PHARMACY CALL US FOR ALL REFILLS.

Signature

Date

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I have received a copy of "HIPAA Notice of Privacy Practices" policy from Charles Street Ob/Gyn Associates, P.A.

Patient Name

Date

I refuse to accept a copy of "HIPAA Notice of Privacy Practices" policy from Charles Street Ob/Gyn Associates, P.A.

Patient Name

Date

MEDICARE

Medicare reimburses for routine (screening) pap smears (lab fees, not visit), once every two years. Our providers generally recommend a routine pap smear be performed every year on patients who have a uterus. I understand that I am responsible for any portion which is not covered by Medicare.

SIGNATURE ON FILE

I authorize Charles Street Ob-Gyn Associates to furnish all medical information necessary to process this claim and request payment of government/insurance benefits to either myself or to the physician who accepts assignment.

I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance and that I will be charged 1.5% interest rate per month, for any account 90 days past due.

SIGNATURE _____ DATE _____